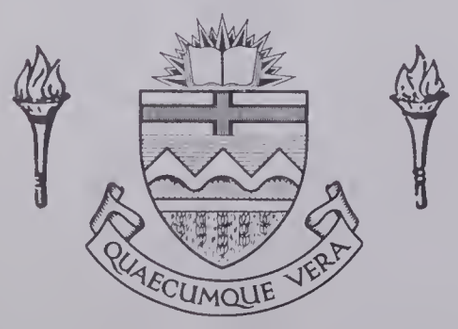

The University of Alberta
Printing Department
Edmonton, Alberta

UNIVERSITY OF ALBERTA

THE INFLUENCE OF PERSONAL ENCOUNTERS ON ATTITUDES

BY

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A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES IN
PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF MASTER OF ARTS

DEPARTMENT OF SOCIOLOGY

EDMONTON, ALBERTA

SPRING, 1970

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled THE INFLUENCE OF PERSONAL ENCOUNTERS ON ATTITUDES submitted by Henry John Regehr in partial fulfilment of the requirements for the degree of Master of Arts.

ABSTRACT

It is assumed that attitudes toward attitude objects are significantly influenced by the interaction between subjects and attitude objects. The question then is posed in this thesis whether the nature of this interaction significantly influences the nature and relative intensity of the subjects' attitudes. This question is investigated in relation to public attitudes toward medical doctors.

Three interaction variables are studied for their influence on attitudes. One, direct personal versus indirect symbolic interaction; two, satisfying versus dissatisfying interaction; and three, the perceived intensity of the subjects' self-involvement in the interaction, that is, how important to themselves the subjects perceive the interaction to be.

The evidence indicates that in general, direct personal interaction affects the intensity of a subject's attitude. Satisfying interaction makes for more favorable attitudes than does dissatisfying interaction. The data relevant to the third variable, perceived intensity of self-involvement, is so meagre that no conclusions have been drawn.

ACKNOWLEDGMENTS

I am most grateful to Professor Bill Meloff who, on very short notice, stepped into the gap as thesis supervisor and gave invaluable guidance and encouragement that was so necessary for the completion of this thesis. My thanks also go to the other members of the examining committee, Dr. C.A. Meilicke and Professor Shirley Stinson, for their time, effort and suggestions that made the completion of this thesis possible.

A second group of people to whom I am deeply indebted are the Alberta Health Care Study team and its director, Dr. Stanley Greenhill, for their generosity in supplying to me the statistical data used in this study. I am in particular grateful to this group for the special concession of allowing me to use the data prior to their publishing any results of this study. In addition to Dr. Greenhill, two other names stand out: Mr. Don Haythorne and Mr. Ron Taylor who went out of their way many a time in order to supply me with the needed survey data.

A special word of thank-you goes to Mr. Gordon Deecker, a competent computer man, who spent many an hour writing and revising a lengthy computer program for the desired calculations.

My thanks also go to Dr. Don Larsen whose penetrating analysis and insightful suggestions contributed much to the development of this thesis from its earlier stages almost to its completion.

Last, but certainly not least, my thanks go to the late Dr. Mary Hendrickson who first served as my thesis supervisor until she was hospitalized on account of the illness that led to

her untimely death on July 6, 1969. Her interest and involvement in studying attitudes among and toward medical personnel was a significant factor in my choice of the topic. Her encouragement and competent suggestions helped to formulate the general strategy of this study. To her belongs much of the credit for the development of this thesis, although she is not around to accept this credit. The gap created by her passing was kindly and capably filled by Professor Meloff. To all a sincere thank-you.

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CHAPTER I

THE PROBLEM

What difference does it make to a person's attitude whether he has a personal encounter with an attitude object or whether he encounters the object only symbolically through communication with other persons? Does a satisfying personal encounter produce an attitude that is significantly different from that produced by a dissatisfying encounter? Does the intensity of an attitude toward an object vary if people attach different degrees of importance to an encounter with that object?

All of these questions have been investigated in different contexts and by means of different research methods. However, as far as can be determined, each question has been studied by itself and not in relation to the other questions. As a result, numerous relevant hypotheses have been corroborated, but their interrelationships have not been delineated. In other words, the question might still be asked: Do persons who have had what they perceived to be an important and satisfying personal encounter with an attitude object exhibit an attitude that is different from the attitude of persons who have encountered the object only through symbolic communication? In what way or degree does the attitude of the former person differ from that of the latter? A further question might be asked: What difference in attitude will be exhibited by a group of persons who have had an important and dissatisfying personal encounter compared to a group of persons who have had a

casual and satisfying personal encounter with a given attitude object?

This study examines the relationship between differences in attitude and different types of encounters with an attitude object. Attitudes toward only one class of attitude objects--medical doctors--are used. Encounters are divided along three dimensions into different types: (1) Symbolic or indirect versus direct, personal encounters; (2) Satisfying versus dissatisfying direct, personal encounters; and (3) Different degrees of perceived intensity of self-involvement, that is, how crucial for his own well-being a person considers an encounter with the attitude object.

This research synthesizes or draws together a number of separate hypotheses into one systematic study. It allows for comparative analysis of the results because the attitude object and attitude questions used are common to all subjects. Furthermore, this approach makes it possible to incorporate all the major findings into one theoretical framework because a common attitude object and attitude questions are used. The effect of each type of encounter on attitude, relative to the effect of each of the other types of encounters, can be determined. In the past, isolated studies have been guided by different theoretical orientations. As a result, theoretical integration of the findings is extremely difficult.

Chapter II reviews the theoretical framework of symbolic interactionism, which serves as the guiding orientation of this study. Emphasis is placed on general theoretical variables which are relevant to the study of attitudes. Numerous empirical studies

in which one or more of the explicated theoretical variables are operationalized and investigated are then reviewed. The purpose of this review is to bring together a set of theoretical propositions, corroborated by empirical evidence, which are the guiding principles of the present study. On the basis of these guiding principles a set of specific, interrelated hypotheses about attitude formation are formulated. Chapter III describes the methodology used to test the hypotheses. The findings are reported and discussed in Chapter IV. Chapter V discusses some theoretical and practical implications of the findings.

CHAPTER II

BACKGROUND OF THE PROBLEM

The nature of a problem is related to the conceptual framework of the viewer of the problem. However, certain features of a problem are seen the same way by many different viewers, regardless of their conceptual framework. For this reason, the theoretical orientation of the viewer and empirically verified facts are essential aspects of investigating a problem. The present chapter will delineate the theoretical framework from which the problem is viewed in this study. Previous research will then be reviewed to find variables that are relevant to the problem, and that are in keeping with the theoretical framework. On the basis of this investigation a number of hypotheses will be formulated.

A. THEORETICAL FRAMEWORK

The theoretical orientation of this study is that of symbolic interactionism. A concise delineation of its major assumptions and their derivatives will therefore be provided in this section. Special emphasis will be placed on those aspects of attitude formation that are relevant to the general questions asked in this study.

1. Symbolic Interaction Theory

Symbolic interactionism grew out of the pragmatic branch of philosophy, which is primarily concerned with practice and only secondarily with knowledge. One basic assumption of symbolic

interactionism, therefore, is that "doing" has primacy over "knowing."[1] Consequently, the unit of social analysis is the social act or interaction. The act does not refer to a simple one-time occurring unit of behavior, but to a process of relating to others. As such, several components of an act can be differentiated. The first sign of an oncoming act is the gesture, which indicates what the organism is about to do. A frequently used illustration are two fighting dogs. The growling and showing of teeth of one dog indicates what he is about to do. Because the act is a process of relating it can never be performed in isolation. The growling dog communicates to the other dog his intention to attack. This evokes an adjustive response, probably defensive action, from the receiver of the gesture. When a gesture facilitates an adjustive response on the part of its receiver, the gesture is said to have meaning. Cognition plays a major role in the mechanism of response facilitation. The receiver of the gesture recognizes it as a sign of a speicific type of behavior, and then is able to counter that anticipated behavior with an appropriate act. A gesture can become a significant symbol if the receiver of the gesture can make an appropriate adjustive response, and the giver of the gesture can anticipate this response from the receiver correctly. In short, both the giver and the receiver interpret the gesture in the same way, and both would respond to it in the same way. Language, or words, are considered to be significant symbols of the highest order. They are tools for relating to other people, ways of interaction, and means of evoking predictable responses from all

members of the group. This is possible because words mean about the same thing to all participants in a particular situation. Linguistic constructs then are of primary importance in human interaction.

A second major assumption of symbolic interaction theory is that humans are both actor and reactor.[2] In relation to this notion, Mead elaborates on man's ability of role-taking. Anticipating the other's response actually involves taking the role of the other and judging from his perspective the most likely response to a given gesture or symbol. Cooley developed the concept of the "looking-glass self,"[3] which, in short, refers to one's imagination of how others see and evaluate oneself and one's reaction to this imagined appearance. Out of the ability to take the role of the other develops a concept of his own "self." Man can be an object to himself from that perspective. It is in this sense that man is both and actor and a reactor. The actor, or principle of action, is what Mead calls the "I"; the "me" is that which is being reacted to.[4] A reciprocal relation and influence exists between the two. The "me" always has reference to the present situation in which one imagines how others view "me." According to Brim, once the situation is past, the "me," which it produced, becomes incorporated into the "I."[5] He argues that "I-me" relationships actually develop from "they-me" relationships, once the "they" becomes sufficiently generalized to sever connections between content and source.

It is in the "I-me" relationships that the concept of self or self-identity originates. Both the "I" and the "me" are integral components of the self. Since the "me" is determined by the given

situation and varies from situation to situation, and in turn, has an impact on the "I," it follows that the self is not a static entity, but is a constantly developing principle of action and reaction. This is the point of view from which symbolic interaction theoreticians approach the study of personality. Personality is seen as a flexible mechanism of action facilitation which can be and is modified by every interaction. Because the "me" is a reflection of the self from others, it follows that others determine, to a large extent, one's personality.[6] By the same token, a rather drastic change of personality can be effected by a change of associates because they are likely to reflect a different "me." A person has, of course, numerous associates or groups of associates with whom he identifies himself in varying degrees. The associates with whom he psychologically identifies himself most and to whose standards he aspires are his "reference groups."[7] More specifically, then, a shift in reference groups can bring about a significant change in personality. Because personality is considered to consist of the pattern of relating to others, it follows that this has significant implications for attitudes. The nature of the reflected "me" determines the patterns of reaction that will be evoked. Attitudes are the responses to the expected behavior patterns evoked by the reflected "me."

A third assumption of this school is that of anti-reductionism,8 which refers to the notion that human behavior cannot be reduced to non-human behavior, just as mental behavior cannot be reduced to non-mental behavior; that is, electro-chemical

processes. Mental concepts loom large in the explanatory system of symbolic interactionism. An extraordinary emphasis is put on such concepts as thinking, volition and self-consciousness as variables intervening between stimulus and response. In this respect, symbolic interactionism differs radically from the Watsonian type of behaviorism which postulates a simple and direct relationship between stimulus and response. Role theorists stress that a person's symbolic environment or his subjective definition of the situation is the prime determinant of the nature of his response. This view offers an explanation for varying responses to what objectively appears as a similar situation.

The assumption of anti-reductionism also suggests that group behavior cannot be understood in terms of the sum of the behavior of the individuals who make up a group. The process of relating to others evokes "emergence," or something that is qualitatively different from isolated acts. A "looking-glass self" thus cannot develop in an individual who is totally isolated from other social beings.

A fourth assumption of symbolic interactionism is that humans enter the world neither social nor anti-social, but asocial.[9] This notion fits well with the contention that interaction is the origin of mind and self, but it almost totally neglects biological factors in human development. The human being comes into the world as a tabula rasa. The content of his social nature in later life is supplied entirely by social interaction. Mind itself is a product of socialization. In view of the fourth assumption, it is not

surprising that symbolic interactionism addresses itself mainly to the problems of socialization. More specifically, the focus is on the process whereby the individual acquires the significant symbols (linguistic constructs), learns the proper response to them, and learns to anticipate the appropriate response from others. As noted earlier, personality is the product of socialization and can, therefore, be modified to a considerable degree by this process.

A fifth assumption of symbolic interactionism is that man is able to manipulate symbols. That is, he can stimulate others and in turn be stimulated by others through symbols. Man can acquire knowledge through the communication of symbols.[10]

A sixth assumption is that motivation is essentially the result of strain for congruence between the "I" and the "me."[11] The "I" expects something of the "me" as reflected in a specific situation. If the reflected "me" is different from what the "I" expected, the person is motivated to do something in an effort to eliminate or reduce this discrepancy.

The symbolic interaction perspective yields several derivations that have a bearing on the formation and change of attitudes. The first one concerns the reflection of the "me." Different groups and situations reflect a different "me." The "me" implies an expected response pattern. For example, the family setting reflects a "me" about the husband and/or father which evokes a specific behavior pattern. This expected behavior pattern is organized into a role or role-set, which is associated with and evoked by a specific situation. Distinct groups and/or situations evoke distinct role-sets.

Secondly, it is because of the organization of role-sets that there is a relative constancy of response patterns to given situations, a phenomenon which was defined above as the effect of attitudes.

Thirdly, these role-sets can be acquired through direct role-encounters or through symbolic communication. A corollary of this derivative is that a role-set can be upset by the failure of one participant of the situation to live up to the expected response pattern. It is at this point that the individual would be susceptible to a change in the expected response patterns. That is, a change in attitude could occur, because the individual is motivated to make the "I" and the "me" congruous. This can be termed a drive for tension reduction. It must be remembered though that this drive for tension reduction is related to the total concept of the self.

2. Interaction Theory and Attitude Formation

The foregoing review of symbolic interactionism suggests a number of variables that are related to attitude formation and change.

The first is the presence or absence of experiences or encounters with a given attitude object. Attitudes are experientially based. There are, however, at least two ways in which an attitude object can be experienced. One, a direct role-encounter with the attitude object, and two, an indirect encounter via symbolic communication with other people. It is suggested here that a distinction between direct and symbolic role-encounters is justified

on the grounds that they affect attitude formation and change differentially. If this suggestion is empirically verified, it ought to be included in the theoretical framework of symbolic interactionism. Direct versus symbolic role-encounters then is a second variable in attitude formation which is suggested but not adequately developed by symbolic interaction theory. A third variable is the degree of congruence between the "I" and the "me." The "me" is a reflection of a given situational encounter with its role-demands. If the role-demands of the situation agree with what the "I" expects, the actor's attitudes toward the implicated attitude objects are confirmed. If they conflict, his attitudes whould change.

Symbolic interactionism does not address itself specifically to the problem of attitude formation and change. For that reason the influence on attitude of various emotional and evaluative factors are not treated. Recognition is accorded to both affective and evaluative aspects in interaction, but their role in the formation of attitudes is not clearly delineated.[12] Other theoretical frameworks, however, address themselves specifically to this problem. Behviorism, for example, postulates that satisfying experiences with a given object result in a favorable attitude toward that object; dissatisfying experiences, in an unfavorable attitude.[13] Similarly, Gestalt theory suggests that values are hierarchically arranged in a person's cognition in terms of their importance. This structure remains relatively constant. One would, therefore, expect that encounters with an attitude object involving values high on a person's value hierarchy will have significant

impact on his attitudes, whereas encounters involving a person's less significant values will have a lesser impact on his attitudes.

3. Summary and Conclusions

In this section symbolic interactionism has been reviewed as a general theoretical framework. On the basis of this review, a number of variables related to attitude formation and change were then specified. An attempt was made to use these variables to find hypothetical answers to the major questions of this study. It was suggested that symbolic interactionism does not provide adequate answers for several aspects of the questions, but that these gaps could be covered by drawing on behaviorism and Gestalt theory.

While symbolic interactionism in its present stage of refinement does not supply adequate answers to all the major questions of this study, it does provide a general perspective from which these questions can be studied. One purpose of this study is to suggest refinements of the theory on specific points related to attitude formation and change.

Reference has been made to a number of specific variables that have a definite bearing on the problem of attitudes. In the following section these variables will be treated with more precision and concreteness by reviewing studies in which they have been investigated.

B. PREVIOUS RESEARCH & ITS THEORETICAL SIGNIFICANCE

The discussion in the previous section points to the importance of considering the following variables with respect to attitude formation and change: (1) The presence or absence of experiences or encounters with a given attitude object; (2) The reward-punishment patterns, or the degree of satisfaction or dissatisfaction resulting from the experience; (3) Degree of congruence between the cognitive and symbolic structure of the "self" and the structure of the actual situations which the subject encounters; (4) The difference between role-encounters with the actual object and through symbolic communication only; and (5) The subject's perceived intensity of self-involvement in the encounters.

In this section the theoretical relationship of each of the above-mentioned variables to attitude formation and change will be discussed. Where possible, the findings of relevant research will be examined. The purpose of this review is to provide a basis for formulating testable hypotheses related to the major questions posed in the first chapter of this study.

1. Behavior - Encounter

One of the major assumptions of symbolic interactionism is that mental processes are the product of experience. Attitudes, which have a mental component, are therefore experientially based, and, by the same token, are changed through experience. Expected behavior patterns within given roles are learned through experience. Man learns how to act appropriately when he comes into contact with an actual situation in which he has to play a role. The situation

defines, to a considerable degree, the nature of the role. From repeated role-encounters the subject learns a behavior pattern that is suited to the given situation. Out of this experience emerges a tendency to respond to the attitude objects involved in the situation in a relatively consistent manner. This tendency is called attitude. Should the situation change so that the subject has to play a different role, his attitude should also change eventually.

There are numerous studies which support the hypothesis that actual role-encounters make for a notable modification of existing attitudes. Two studies which support this proposition will be mentioned here. One study, conducted by Culbertson,[14] sought to test the magnitude of attitude change as a result of role-playing. Subjects were asked to behave in ways that were counter to their attitudes. A control group simply watched the performance of the experimental group. Culbertson found that attitude modification was notably greater for participants than for observers.

Similar findings were noted in a series of studies by Janis, King, and Gilmore.[15,16,17] They found a differential effect of what they called "improvisation" of a role, as compared to simple observation of a role. Subjects who had improvised a given role showed a significant attitude modification in the direction consistent with the improvised role.

The presence or absence of an actual role-encounter with an attitude object thus appears to be an important variable in attitude change. Presumably, if no role-encounter with a given

attitude object has been experienced, there will be no notable tendency toward a consistent response pattern with reference to the given attitude object.

2. Satisfaction versus Dissatisfaction

It is evident that not all role-encounters influence an individual's attitude in the same manner or to the same degree. The nature of an encounter makes for a differential influence on attitude. According to behaviorism, an encounter which yields self-satisfaction reinforces its constituent behavior patterns to the extent that they become attitudinal tendencies. Satisfaction, in this theoretical framework, is limited to biological drive reduction.

Symbolic interactionism, too, stresses satisfaction in encounters as an important variable which influences a person's attitude. However, in this perspective the concept of satisfaction is enlarged to take account of man's social nature. Encounters take place within a social context in which the expectations of others have considerable influence in determining the behavior patterns that yield satisfaction of sufficient magnitude to function as reinforcers for these behavior patterns.

Whether related to biological drives or social incentives, studies bear out that satisfaction has a definite influence on attitude formation and change. Perhaps the most extensive series of studies with respect to the satisfaction variable has been conducted by the Yale Communication group under the direction of Carl Hovland.

> In studying the process of attitude change, they [Hovland and associates] have investigated primarily three types of incentive: Direct gains of money, health, security or the like if the attitude is altered; social approval, prestige, and group acceptance resulting from attitudes similar to those held by respected individuals or groups; and self-approval, such as feeling right or wrong or feeling that one is being manipulated or treated with respect.[18]

Rosenberg, a member of the Yale Communication group, investigated the influence of amount of money paid to the subject. Subjects were asked to write an essay in support of an issue with which they disagreed. Rosenberg found that the greater the amount paid, the more the subject's attitude changed.[19] Janis and Gilmore, on the other hand, obtained evidence that amount of money per se did not directly influence attitude change. Instead, they found that monetary rewards in combination with social and/or self-approval produced considerable attitude change.[20] Subjects were asked to write an essay elucidating arguments for a proposed policy change. One group was told that the proposed change was sponsored by a Public Welfare agency which was considered to have social approval. Another group was told that the policy was sponsored by blatantly commercial interests. Subjects who were paid a high amount and were made to believe the proposed change was sponsored by a Public Welfare agency, showed a great deal of attitude change. There were two sources of satisfaction for these subjects: One, the monetary rewards, and two, sponsorship by the Public Welfare agency brought the issue in line with a generally favorable predisposition toward Public Welfare. As a result, the subjects' attitude toward the issue in question became significantly more favorable. No appreciable difference was found with respect to attitude change among the

other subjects.

In studying the relative effectiveness of one-sided versus two-sided communication the Yale Communication studies showed that the two-sided approach is more effective with those persons who were initially opposed to the argument, and with the better educated. Furthermore, regardless of subjects' original conviction, in the long run the two-sided approach was superior. On the other hand, the one-sided approach was more effective when facts in support of the "other side" were unfamiliar.[21] The conclusion from these findings is that if a subject senses that he is being manipulated, he resists attitude change. Being manipulated degrades his self-concept. This yields dissatisfaction, and therefore, has a negative influence on attitude change. At the very least, dissatisfaction prevents the subject from developing a favorable attitude, even though external pressures favor this development. Often dissatisfaction is followed by resentment on the part of the subject.

In short, these studies stress the importance of the satisfaction variable in attitude formation and change. Encounters which yield satisfaction tend to produce favorable attitudes toward the attitude objects involved; encounters which yield dissatisfaction produce unfavorable attitudes.

3. Symbolic Structure of Actor and Situation

The human personality is a structured unit consisting of cognition, values, feelings, and action patterns. The structure of this unit persists over a period of time. This structured personality comes into contact with the structure of external conditions which

impinge on man's perception and, therefore, on his action.

There are then two symbolic structures involved in any human action: One, the symbolic structure of the self and two, the structure of the situation to which the self reacts. The former has been designated by Mead as the "I," or the generalized other. Warshay denotes it as "perspective" or "frame of reference" and theoretically describes it as follows:[22]

> Perspective is a symbolic structure that the actor brings to situations, consisting of meanings (or concepts), ideas and values in different states of clarity and coherence.
>
> Perspective serves as a frame of reference, running ahead of situations, making for definitions of situations.
>
> Perspective, therefore, determines the kind of definitions possible in a given situation, being broader for some and narrower for others.
>
> Perspective is learned, largely through symbolic interaction.
>
> Symbolic interaction, involving as it often does, role-taking and role-playing, leads to a good deal of one's perspective being closely organized around one's self or selves.

Perspective then includes attitudes which manifest themselves in a tendency to react to a given situation in a consistent manner.

There is however, another symbolic structure that impinges on man's perspective. This is the structure of the actual situation. Symbolic interactionists usually refer to it as role or role-set, which carries with it expected behavior patterns of all participants. The expected behavior patterns are, of course, the result of previous encounters with the given role and as such are "predicated upon a common universe of discourse"[23] by all those implicated in that activity.

The important variable with respect to attitude is congruence of definitions of the situation between the actor's perspective and

the role structure of the real situation. If this congruence is lacking, disorganization follows. At the point of incongruent definitions the attitudes of the participants are most susceptible to change.[24]

It should be noted that perspective includes the expected behavior patterns to many situations or roles which have been encountered in the past. Consequently, man can choose a given behavior pattern and project it onto a given situation. Cottrell argues that the definition of the situation is in actuality selecting a self-other (behavior) pattern. He further notes that established self-other patterns tend to be projected on many similar, but not necessarily identical, situations.[25] If then the situation is incongruent with the selected self-other pattern, conflict results. This conflict can be resolved by selection of another self-other pattern. Consequently, an attitude can change quite quickly as a result of encountering a situation which generates an expected self-other pattern at variance with that of the individual's perspective.

4. Symbolic versus Direct Role-Encounters

Symbolic interactionism postulates that all of reality is cognitively represented by means of symbols which are contingent upon action or interaction. A corollary of this notion, and an actual assumption of symbolic interactionism, is that symbols can be, and often are, manipulated apart from the reality which they represent. Consequently, there must be two distinct ways of encountering roles and acquiring role-related expected behavior

patterns: One, direct role-encounters in concrete situations, and two, indirect role-encounters through communication of symbols. The studies discussed below, show that this conceptual distinction is justified in that the two types of encounters have differential effects on attitude formation and change.

Janis and King, attempting to investigate the differential effects of "active versus passive" participation, administered three types of communication to an experimental group, who later had to verbalize their opinions concerning its content (active participation), and a control group who only had to listen to the communications (passive participation). They found that the experimental group showed a significantly greater amount of opinion change than did the control group.[26] A follow-up study, which sought other variables that could have been related to the observed differences, concluded that the crucial variable is "improvisation versus non-improvisation of a role."[27] That is, those who were required to improvise a role showed a greater amount of opinion change than those who did not have to improvise. In a later study, Janis and Gilmore found that high monetary rewards did not produce significant attitude changes, but that high monetary rewards in combination with overt role-playing did.[28]

In a similar study, Watts defined "passive participation" as reading on a topic and "active participation" as writing on a topic. He found that after six weeks, active participation was clearly superior to passive participation in retention of opinion change.[29]

Perhaps the most specific study of the difference in impact on attitudes between direct and indirect role-encounters was conducted by Frances Culbertson, who had subjects justify, by means of psychodrama, an issue that evoked much emotional opposition. Another group only had to observe or listen to this defense. The psychodrama group showed significantly more attitude change than did the observer group.[30] Comparison of both groups to a control group showed that both methods induced some opinion change.

Howard Becker's studies of marihuana users[31,32] also provide insight into the relationship between direct role-encounters and attitude change. Becker observed that in order to become a marihuana user, one must associate with the "right" type of people for two reasons: One, the original effects of marihuana use are such that continuation is highly unlikely if emotional and moral support from associates is not forthcoming; and two, failure to maintain the "right" type of relations interrupts the supply of marihuana which has a traumatic effect on the user's self-concept because it has such far-reaching consequences on satisfying his drives. Becker further observed that, originally, the user is fearful of being in the presence of non-users when he is "high," despite the assurances from associates that it is safe. However, with one or two successful experiences in interaction with non-users, this fear diminishes. A similar pattern takes place with respect to the individual's moral sensitivities. Users report severe conscience scruples upon initial use of the drug. However, encounters with non-users failed to reflect a morally condemned self concept. As a result the conscience scruples abated.

The implication of these studies is that symbolic and direct role-encounters affect attitudes in differential magnitudes, with direct encounters having a greater effect than symbolic encounters. A theory, which in part reflects this proposition , was developed by Leon Festinger and has come to be known as the "theory of social comparison." Festinger states that "to the extent that objective, non-social means are not available, people evaluate their opinions and abilities by comparison respectively with the opinions and abilities of others."[33] But "when an objective, non-social basis for the evaluation of one's ability or opinions is readily available, persons will not evaluate their opinions or abilities by comparison with others."[34] Perhaps the choice of the term "non-social" is unfortunate because the terms "objective" and "non-social" do not refer to mutually exclusive phenomena. The indication is that an objective, direct encounter with an attitude object will produce an opinion or attitude that is stronger than an opinion or attitude that is acquired through symbolic communication with others. This strongly suggests that direct role-encounters have a greater effect on attitude formation and change than do symbolically facilitated role-encounters.

5. Perceived Intensity of Self-Involvement

Not all encounters with attitude objects are of equal importance to an individual. He judges some encounters to be of greater significance than others. If basic components of his self concept are involved, the encounter is judged to be crucial; otherwise, the encounter has less significance. This concept is referred to as

"perceived intensity of self-involvement."

George H. Mead did not address himself to the problem of a subject's perceived intensity of self-involvement. In his view, man's activity is rationally oriented.[35] Stryker argues, on the other hand, that a person's traditional values and affective relationships are important influences on his behavior. He suggests that these factors constitute an integral part of a subject's self-concept and, as such, they influence his judgement of how important a given encounter with an attitude object is to him.[36] Cooley's emphasis on "signifcant others" implies that affective relationships can, and often do, supersede purely rationalisitic considerations in an individual's definition of the situation. Similarly a person's traditional or established values influence his definition of this situation. The implication of the foregoing discussion is that an individual will judge an encounter significant if important aspects of his self-concept are involved, be they rationalistic, affective or traditional. It is further implied that the more intense he perceives himself involved in a given encounter, the greater will be the impact of that encounter on his attitude toward all the attitude objects involved.

A study in support of this point was done by M.B. Smith, who interviewed three-hundred adults to determine their opinion about the foreign policy the United States should adopt toward Russia.[37] He also related given opinions to the subjects' personality traits. Smith found no relation between a subject's level of information on an issue and the direction of his opinion. A subject's opinion, however, was directly related to his "intensity

of concern."[38] Smith concluded that "intensity is a function of the importance of this engaged value in the hierarchy of the person's central values."[39]

Further support for the relationship between the degree of perceived intensity of self-involvement and attitude change comes from two studies by Dutta and Kanungo.[40,41] They investigated the influence of "perception of differential intensity of affect" on retention of learned material. Their conclusion is that retention is a function of the perceived intensities of unpleasant and pleasant effects. One can deduce from this finding that better retention of learned material is a result of greater original impression and, as such, greater influence on attitude and opinion change should be its effect.

The concept of perceived intensity of self-involvement has also been used to explain why certain groups of people make proportionately more use of health care facilities than do other groups. I.W. Rosenstock isolated "perceived seriousness of illness" as an important variable in determining who seeks medical help.[42] S. King claims that observed class-based differential use of health care is due to class-based differential recognition of the seriousness of symptoms. He does this on the evidence of two empirical studies. The first one, Koos' Regionville study, showed that perceived intensity of seriousness of symptoms varied directly with class. The second study, conducted by Feldman and Sheatsly of NORC, showed that recognition of symptoms varied directly with education and income.[43]

6. Summary

The foregoing review of relevant literature indicates that the variables selected for investigation influence attitude formation and change in the following ways: First, a person's attitude toward a given attitude object is relatively decisive and stable if it is a consequence of actual experience with the attitude object. Decisiveness and consistency of attitude are weak if no experience with the attitude object has taken place. Second, satisfying experiences with an attitude object generate favorable attitudes toward that object; dissatisfying experiences produce unfavorable attitudes. It was shown that satisfaction involves reduction of biological drives, social approval which is a result of complying with the expectations of others, and self-approval which implies consistency with one's basic orientations to life and reality. Third, variance between a person's structured expectations and the role demands of a given situation which he encounters tends to produce attitude change. Fourth, direct role-encounters have a greater impact on attitude formation and change than do symbolic role-encounters. Fifth, the more a person perceives his basic values involved or threatened in a given encounter, the greater the impact of that encounter on his attitudes.

In the next section these variables will be used to formulate specific and interrelated hypotheses.

C. HYPOTHESES AND THEIR THEORETICAL IMPLICATIONS

Only three of the variables discussed in the previous section will be translated into operational terms for empirical investigation. These are: (1) Direct versus symbolic role-encounters with a given attitude object, (2) Satisfaction versus dissatisfaction resulting from role-encounters, and (3) Perceived intensity of self-involvement.

For reasons that will become clear later, the second variable--satisfaction versus dissatisfaction--is used first to formulate a specific hypothesis. Satisfaction yields a favorable attitude toward the attitude object invoved; dissatisfaction, an unfavorable one. It is the direction of attitude formation or change that is influenced by this variable. The following hypothesis can now be stated:

Hypothesis 1

> Persons who have had satisfying role-encounters with a given attitude object will exhibit a more favorable attitude toward that object than persons who have had dissatisfying role-encounters with that attitude object.

The "satisfaction versus dissatisfaction" variable provides an external criterion in relation to which the differential impact of direct and symbolic role-encounters on attitudes can be determined. For this reason, an hypothesis involving this variable was formulated first. Hypothesis 2 assumes verification of Hypothesis 1.

Given the assumption of attitude acquisition through communication of symbols, it follows that subjects will not be

neutral toward an attitude object that is prevalent in their environment. Instead, in the absence of direct role-encounters with an existing attitude object, people will acquire attitudes toward that attitude object via symbolic communication with their interaction group. Consequently, their attitude toward the given attitude object will be similar to the attitude of their interaction group. Direct role-encounters, however, tend to override prior attitudes, according to evidence cited in the previous section. In short, direct role-encounters have a greater influence on attitude formation and change than sheer communication of symbols. Consequently, when a comparative group is used, which is composed of subjects who have acquired their attitude toward the given attitude object only through symbolic communication, the following results are predicted:

Hypothesis 2

a. The comparative group will exhibit a less favorable attitude toward the given attitude object than subjects who have had satisfying role-encounters with that attitude object.

b. The comparative group will exhibit a more favorable attitude toward the given attitude object than subjects who have had dissatisfying role-encounters with that attitude object.

It is hypothesized that the third variable to be tested empirically--perceived intensity of self-involvement--will make for a further subdivision of the low-to-high-favorableness-of-attitude continuum. Among those who have had direct role-encounters with the given attitude object the following relationships are expected to hold:

Hypothesis 3

a. Among those who have had satisfying role-encounters, favorableness of attitude will vary directly with perceived intensity of self-involvement.

b. Among those who have had dissatisfying role-encounters, favorableness of attitude will vary inversely with perceived intensity of self-involvement.

A summary of the three hypotheses and their interrelationships is presented in graphic form below.

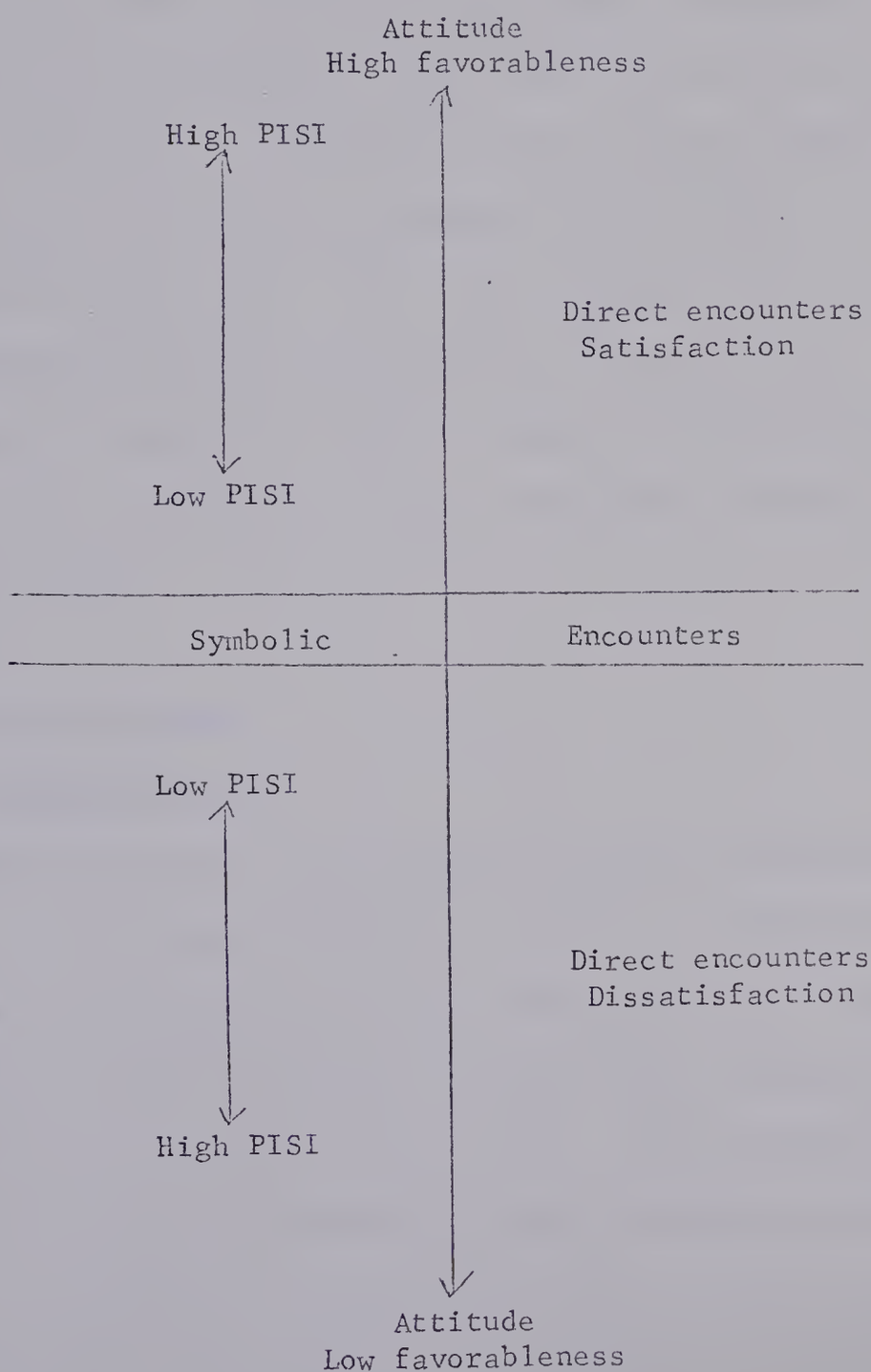
Symbolic interaction theory, in general, is rather rationalistic, assuming that all role-encounters have about equal weight in forming and modifying the self, of which attitudes are a part. Verification of our hypotheses would suggest that symbolic interaction theory should be extended to include the differential weight of influence of various emotional factors implicated in a given role-encounter. It would also suggest a distinction between direct role-encounters and symbolically communicated role-encounters and their differential weights of influence on attitude formation and change.

In the following chapter these hypotheses will be operationalized and the methods by which they will be tested, described.

Graphic Presentation of Predicted Results

Variables

1. Direct (DE) versus symbolic encounters (SE)
2. Satisfaction versus dissatisfaction
3. Perceived intensity of self-involvement (PISI)



CHAPTER III

METHODOLOGY

The data used in this investigation are derived from a larger research project which studied the utilization of health services. The selected portion of data deals with general attitudes toward health care personnel. This chapter describes the operational concepts, indicators and procedures used to test our hypotheses. The concepts are (1) population sample, (2) attitudes, (3) interaction group, (4) direct versus symbolic role-encounters, (5) satisfaction versus dissatisfaction with doctors, and (6) perceived intensity of self-involvement. The hypotheses are then restated in operational terms. A description of the statistical analysis follows.

A. OPERATIONAL CONCEPTS

1. Population Sample

From the Voters List, prepared in terms of enumeration districts, for the May, 1967 Alberta election, a probability sample of households was drawn from each of several districts. Detailed interviews with adults (18 years and over) were conducted by trained interviewers using standard forms. Proxy interviews were permitted. Information regarding attitudes could not be obtained by proxy. Consequently, the attitude section was left blank on proxy interviews. These then were excluded from our sample. The representativeness of the population sample used in this study is

therefore rendered questionable. However, representativeness is not deemed an important issue for the propositions of this study, and therefore, no test was made on the possible extent of sample bias.

All adult respondents from two enumeration districts make up the total sample. These districts are:

1) Rural distirict east and west of Red Deer.

2) Urban district of Edmonton

The reason for this choice was the desirability to distinguish between subjects of rural residence and those of urban residence.

2. Attitudes

Attitudes were measured from verbal responses to questions relating to three health-related concepts, which are mentioned below. Each question could be answered in one of three ways: agree, disagree, or don't know. Questions were worded in either a positive or negative way. Each question was weighted according to a modified version of a procedure proposed by R. Francis.[1] The percentage of positive and negative responses was computed for each question in order to make a test of the discriminative power of a question relative to a concept. The percentage difference between "agree" and "disagree" of each statement was used to assign the weighting of its discriminative power. The following table shows the percentage differences and their corresponding weightings.

Percentage difference	Example	Weightings
60-80%	85% A; 15% DA	1
40-59%	75% A; 25% DA	2
20-39%	65% A; 35% DA	3
0-19%	55% A; 45% DA	4

The three attitude concepts and the statements of which they are composed are listed below. The response which appears in brackets after each statement is that which indicates a positive response to the given concept. The digit following the response is the weighting assigned to the question.

1) Tendency to Use Medical Care Services (TUMC)

(1) I like to know about illness in others so that I may learn its cure (disagree, 3).

(2) As long as you feel all right there is no reason to go to a doctor (disagree, 4).

(3) I would rather not go to a doctor unless I have to (disagree, 1).

(4) Being examined by doctors bothers me (disagree, 2).

(5) Even if you don't go to a doctor, you can get over almost any disease (disagree, 1).

(6) Even if a person is not sick he should see a doctor at least twice a year (agree, 4).

2) General Satisfaction with Physicians (GSP)

(1) Doctors tend to send people to other doctors too often (disagree, 1).

(2) Doctors don't take enough interest in their patients (disagree, 3).

(3) Doctors are interested as much in their patients' well being as they are in their own (agree, 2).

(4) I generally understand the words doctors use (agree, 3).

(5) Instructions doctors give you are generally detailed enough (agree, 1).

(6) Doctors usually don't spend enough time with the people who go to see them (disagree, 3).

(7) Doctors tell you to come back to see them more often than is necessary (disagree, 1).

3) Skepticism toward Doctors (SD)

(1) When I am ill and go to a doctor, I insist on knowing all the details of what is being done to me (agree, 3).

(2) The drugs doctors prescribe are always better than home remedies (disagree, 2).

(3) If you strictly follow doctors' orders, you won't have much illness in your life time (disagree, 4).

(4) I have my doubts about some things doctors say they can do for you (agree, 3).

(5) I think it best to try out different doctors to find which one I think will give me the best care (agree, 3).

(6) For most kinds of illnesses, no one can help you as much as a doctor can (disagree, 1).

(7) Doctors can prevent most serious diseases (disagree, 4).

(8) When I go to a doctor I sometimes suggest treatments different from those he prescribes (agree, 1).

The maximum possible score for each concept that a respondent could obtain was determined by adding the weightings of its component statements. The minimum possible score is zero.

Concept	Maximum possible score
TUMC	15
GSP	14
SD	21

3. Interaction Group

There is no direct way to determine from the interview schedule the groups with which an individual interacts. There are, however, two indicators from which a general interaction group can be inferred, namely, place of residence and education. E. Suchman found that these two variables were significantly related to a person's predisposition toward medical care.[2] Urbanism and education are indicative of a scientific orientation and therefore of a favorable predisposition toward medical personnel.

(1) Residence

Only two classifications were made, and this was done on the basis of the districts from which the sub-samples were drawn.

a) Rural - east and west of Red Deer

b) Urban - Edmonton

(2) Education

This was determined from responses to the question: How much formal education do you have?

No formal schooling
Elementary school
Junior high school
Some high school
Completed high school
Some university
University degree

For practical purposes, several of the above categories were collapsed so as to make only three classifications of education. These are:

a) Low - No formal schooling
- Elementary school

b) Medium - Junior high school
- Some high school
- Completed high school

c) High - Some university
- University degree

From these two indicators--residence and education--an index of Predispostion Toward Medical Personnel (PMP) was constructed as outlined in the following table.

	RESIDENCE	
EDUCATION	Rural	Urban
Low	1	2
Medium	2	3
High	3	4

On the basis of this table, respondents were divided into four categories of Predisposition toward Medical Personnel as follows:

Category 1 - Persons with low education and rural residence

Category 2 - Persons with low education and urban residence, and those with medium education and rural residence.

Category 3 - Persons with medium education and urban residence, and those with high education and rural residence.

Category 4 - Persons with high education and urban residence.

4. Direct versus Symbolic Role-Encounters

This was determined from responses to the following questions:

(1) During the last two weeks have you seen or consulted a doctor about your health? (Answer: Yes or No).

(2) (If no) When did you last see a doctor?
In the last 12 months
1-5 years
More than 5 years
Never

Those who answered "Yes" to question 1 were considered as having had direct role-encounters with the attitude object. The remainder of the sample, except those who answered "In the last 12 months" to question 2, were considered as not having had direct role-encounters. The decision to discard those who had seen a doctor within the last 12 months, but not within the last two weeks, was somewhat arbitrary. However, it was reasoned that the encounter could have been fresh enough in the repondents' memory that it could have significantly influenced their attitude. Since we have no information as to the nature of their encounters with a doctor, we could not easily classify them as either "satisfied" or "dissatisfied."

5. Satisfaction versus Dissatisfaction with Doctors

This was determined from responses to the following questions:

(1) Did you have a long wait at the doctor's office or not? (Answer: Yes or No).

(2) Did the doctor take enough time, or not enough time, in examining you? (Answer: Enough, not enough).

(3) Did the doctor take enough time to discuss things with you, or not? (Answer: Enough, not enough).

(4) Were you satisfied or dissatisfied with the visit or consultation? (Answer: Satisfied, dissatisfied).

Data for the main variable of "satisfaction versus dissatisfaction" were taken from question 4. The peripheral questions

(1, 2, 3) were included to get some idea of the underlying dimension of the "satisfaction versus dissatisfaction" variable.

6. Perceived Intensity of Self-Involvement (PISI)

Perceived intensity of self-involvement was determined from reponses to the following questions, which were asked about the condition which prompted the visit to the doctor:

(1) Would you say this sickness bothered you
A great deal?
Somewhat?
Hardly at all?
Not at all?

(2) Did you consider this condition
Extremely serious?
Rather serious?
Not very serious?
Not serious at all?

In both questions, the four response categories were collapsed into two:

(1) a. A great deal; somewhat.
b. Hardly at all; not at all.

(2) a. Extremely serious; rather serious.
b. Not very serious; not serious at all.

	Extremely serious Rather serious	Not very serious Not serious at all
A great deal Somewhat	3	2
Hardly at all Not at all	2	1

The above table shows the three categories of "perceived intensity of self-involvement," numbered in the order from lowest to highest intensity.

Category 1 - Low PISI

Category 2 - Medium PISI

Category 3 - High PISI

Those respondents who did not consult a doctor within the last year were used only as a comparative or control group. The average scores of their "tendency to use medical care," "general satisfaction with physicians," and "skepticism toward doctors" was computed for each of the categories of "predisposition toward medical personnel." These scores were used as a baseline for comparing corresponding scores of the study group; i.e., those respondents who had seen a doctor within the last two weeks.

The following specific hypotheses, stated in terms of operational concepts and indicators, were investigated,

B. TEST HYPOTHESES

1. Involving only the study group:

a. Within each category of "predisposition toward medical personnel", "tendency to use medical care" will be higher for those respondents who were satisfied than for those who were dissatisfied.

b. Within each category of "predisposition toward medical personnel", "general satisfaction with physicians" will be higher for those respondents who were satisfied than for those who were dissatisfied.

c. Within each category of "predisposition toward medical personnel," "skepticism toward doctors" will be lower for those respondents who were satisfied than for those who

were dissatisfied.

2. Comparison of study group with comparative group:

   a. For those who were satisfied, "tendency to use medical care", and "general satisfaction with physicians" will be above and "skepticism toward doctors" below the coresponding scores of the comparative group when "predisposition toward medical personnel" is held constant.

   b. For those who were dissatisfied, "tendency to use medical care," and "general satisfaction with physicians" will be below and "skepticism toward doctors" above the corresponding scores of the comparative group when "predisposition toward medical personnel" is held constant.

3. Involving only the study group:

   a. Among those who were satisfied, when "predisposition toward medical personnel" is held constant:

      1) "Tendency to use medical care" will vary directly with "perceived intensity of self-involvement."

      2) "General satisfaction with physicians" will vary directly with "perceived intensity of self-involvement."

      3) "Skepticism toward doctors" will vary inversely with "perceived intensity of self-involvement."

   b. Among those who were dissatisfied, when "predisposition toward medical personnel" is held constant:

      1) "Tendency to use medical care" will vary inversely with "perceived intensity of self-involvement."

      2) "General satisfaction with physicians" will vary inversely with "perceived intensity of self-involvement."

3) "Skepticism toward doctors" will vary directly with "perceived intensity of self-involvement."

C. STATISTICAL PROCEDURES

After the subjects were divided into categories of "predisposition toward medical personnel" and "perceived intensity of self-involvement," the average score of each category for each attitudinal dimension was computed. The resulting scores are given in Tables I-XI of the following chapter.

D. SUMMARY

This chapter has described in operational terms the concepts, variables, and procedures used in testing the hypotheses of this study. The hypotheses developed in Chapter II have been restated in operationalized terms as "Test Hypotheses." In the following chapter the computations and findings are reported and discussed.

CHAPTER IV

ANALYSIS OF SURVEY DATA

This chapter describes the statistical computations which are performed in order to test the aforementioned hypotheses. The actual results are reported. Comparisons are made between the attitude scores of appropriate categories to see whether the predicted relationships between variables hold.

A. POPULATION SAMPLE

Persons about whom information was obtained by proxy interview were eliminated from our sample. Furthermore, those who had seen a doctor within the last two weeks prior to the interview were also eliminated from the sample for reasons given in the previous chapter. This left a total sample of 802 respondents. Of these, 541 had indicted that they had not seen a doctor within the last year. They comprise the comparative group. The other 261 subjects comprise the study group who had seen a doctor within the two weeks preceding the interview.

B. ATTITUDES OF THE COMPARATIVE GROUP

As explained in chapter III, the respondents were divided into four categories of PMP (predisposition toward medical personnel). Variables used in this categorization are 1) Place of residence, and 2) Amount of education.

The average attitude score for each category of PMP was calculated in relation to the three attitudinal concepts of TUMC

(tendency to use medical care), GSP (general satisfaction with physicians), and SD (skepticism toward doctors). The findings are recorded in Table I.

Table I: Average attitude scores of comparative group by categories of PMP

Attitudinal Concept	PMP 1 (N=54)	2 (N=296)	3 (N=163)	4 (N=24)
TUMC	6.69	6.99	6.85	7.13
GSP	7.02	8.93	8.60	8.42
SD	8.43	8.57	8.54	9.25

N=number of respondents in each category

This table is used as a base of comparison for different attitude scores of the study group.

C. ATTITUDES OF THE STUDY GROUP

The influence on attitudes of two variables: 1) Satisfaction versus dissatisfaction, and 2) Perceived intensity of self-involvement (PISI) was tested on the study group.

1. Satisfaction versus Dissatisfaction

The study group was divided into those who were "satisfied" and those who were "dissatisfied" with their doctor visit. Each of these sub-groups were divided into PMP categories and the average attitude score for each category was computed. The attitude scores for those who were "satisfied" are given in Table II. Table III records the attitude scores for those who were "dissatisfied."

Of the 261 respondents of the study group, 224 indicated that they were "satisfied" with their doctor visit and 22 indicated that they were "dissatisfied." For the other 15 respondents no answer to the question of "satisfied versus dissatisfied" was recorded. The survey team indicated that this was probably due to an oversight on the part of the interviewers.

Table II: Average attitude scores for "satisfied" respondents of study group by categories of PMP

Attitudinal Concept	PMP 1 (N=15)	2 (N=110)	3 (N=86)	4 (N=12)
TUMC	8.07	7.45	8.51	8.75
GSP	9.67	10.20	10.33	11.25
SD	8.07	8.54	7.70	9.50

N=number of respondents in each category

The first hypothesis of this study involves the comparison of attitude scores of the "satisfied" respondents to the "dissatisfied" respondents of the study group. The hypothesis predicts that the TUMC and GSP scores will be higher and the SD scores will be lower for the "satisfied" respondants than for the "dissatisfied" ones. A rearrangement of the data of Tables II and III, as recorded in Tables IV, V, and VI, shows the relationship of the "satisfaction versus dissatisfaction" variable to attitude scores.

Table III: Average attitude scores for "dissatisfied" respondents of study group by categories of PMP

	PMP			
Attitudinal Concept	1 (N=1)	2 (N=11)	3 (N=9)	4 (N=1)
TUMC	5.00	7.09	8.00	5.00
GSP	7.00	8.09	6.22	10.00
SD	8.00	8.82	9.67	18.00

N=number of respondents in each category

The N's in Table III are considerably lower than the N's in Table II. Seemingly many more people are satisfied with their doctor visit than are dissatisfied. It may be indicative of the high prestige that medical doctors enjoy in our society. Reference will be made to the low N's in Table III when tests of significance are discussed.

Table IV: Average TUMC scores for "satisfied" and "dissatisfied" respondents

	PMP							
	N	1	N	2	N	3	N	4
Satisfied	15	8.07	110	7.45	86	8.51	12	8.75
Dissatisfied	1	5.00	11	7.09	9	8.00	1	5.00

Highest possible score=15; lowest possible score=0

The predicted relationship is shown in the above table. In

each category of PMP, the TUMC scores are higher for the "satisfied" respondents than they are for the "dissatisfied" ones. In categories 2 and 3 the differences are only small (.36 and .51 respectively). In categories 1 and 4 the differences are substantial (3.07 and 3.75 respectively). The fact that there is only one "dissatisfied" respondent in categories 1 and 4 counsels caution with respect to any conclusion. The direction of influence on attitude of the "satisfaction versus dissatisfaction" variable, however, is clear, but the relationship is weak.

Table V: Average GSP scores for "satisfied" and "dissatisfied" respondents

	PMP							
	N	1	N	2	N	3	N	4
Satisfied	15	9.67	110	10.20	86	10.33	12	11.25
Dissatisfied	1	7.00	11	8.09	9	6.22	1	10.00

Highest possible score=14; lowest possible score=0

The predicted direction of influence is corroborated by the data of Table V. The differences between "satisfied" and "dissatisfied" are considerably greater for GSP than for TUMC. It is noteworthy that the differences are substantial in those categories with the highest number of respondents.

In general, the predicted relationship between the "satisfaction versus dissatisfaction" variable and SD is verified. In category 1 a slight difference in the opposite direction of that predicted is found.

Table VI: Average SD scores for "satisfied" and "dissatisfied" respondents

PMP

	N	1	N	2	N	3	N	4
Satisfied	15	8.07	110	8.54	86	7.70	12	9.50
Dissatisfied	1	8.00	11	8.82	9	9.67	1	18.00

Highest possible score=21; lowest possible score=0

In category 4 a great difference in the predicted direction is observed. Since each of these categories contains only one "dissatisfied" respondent, conclusions based on this evidence are precarious. However, categories 2 and 3 bear out the predicted relationship. Category 3 shows a substantial difference between "satisfied" and "dissatisfied" respondents.

In eleven out of twelve comparisons, hypothesis 1 is supported by the survey data. The one case which indicates a relationship opposite to that predicted shows only a small difference between "satisfied" and "dissatisfied" respondents and has a very low N.

2. Direct versus Symbolic Role-Encounters

A test of hypothesis 2 requires a comparison of attitude scores of the comparative group to those of the "satisfied" and the dissatisfied" respondents of the study group. Verification of hypothesis 2 requires that the scores of the comparative group be between the scores of the "satisfied" and the "dissatisfied" respondents in the following manner: TUMC and GSP scores are above and SD below the scores of the comparative group for the "satisfied" respondents;

TUMC and GSP scores are below and SD above the scores of the comparative group for the "dissatisfied" respondents. Tables VII, VIII, and IX report the attitude scores in a way that is appropriate to a test of hypothesis 2.

Table VII: Average TUMC scores for "satisfied" respondents, comparative group, and "dissatisfied" respondents

	PMP							
	N	1	N	2	N	3	N	4
Satisfied	15	8.07	110	7.45	86	8.51	12	8.75
Comparative group	54	6.69	296	6.99	163	6.85	24	7.13
Dissatisfied	1	5.00	11	7.09	9	8.00	1	5.00

Highest possible score=15; lowest possible score=0

Only categories 1 and 4 support the predicted relationship. Each of these categories has only one "dissatisfied" respondent which makes any conclusions tenuous. Categories 2 and 3, which contain most of the respondents, show the comparative group having the lowest scores. This appears to challenge hypothesis 2.

A possible explanation for the observed relationship is found in the nature of the attitudinal concept in question. The "tendency to use medical care" is something that the comparative group has not shown for at least a year. (By definition, the comparative group consists of those respondents who have not consulted a doctor within the last 12 months). Perhaps there has been no need for them to

consult a doctor. In short, they may not have encountered situations in which a doctor would have been of significant help to them. Consequently, they do not exhibit as strong a tendency to use medical care as do those who have encountered the need to do so.

Table VIII: Average GSP scores for "satisfied" respondents, comparative group, and "dissatisfied" respondents

	PMP							
	N	1	N	2	N	3	N	4
Satisfied	15	9.67	110	10.20	86	10.33	12	11.25
Comparative group	54	7.02	296	8.93	163	8.60	24	8.42
Dissatisfied	1	7.00	11	8.09	9	6.22	1	10.00

Highest possible score=14; lowest possible score=0

Table VIII supports hypothesis 2, with the exception of the lone "dissatisfied" respondent of category 4. In each category, the "satisfied" respondents have significantly higher GSP scores than do the comparative group. The "dissatisfied" respondents of categories 2 and 3 have significantly lower GSP scores than do the comparative group.

Hypothesis 2 predicts SD to be lower for the "satisfied" and higher for the "dissatisfied" respondents than it is for the comparative group. The lone "dissatisfied" respondent of category 1 does not agree with this prediction. Also the "satisfied" respondents and the comparative group of category 4 challenge hypothesis 2. A check of Tables VII and VIII reveals that the 12 "satisfied"

Table IX: Average SD scores for "satisfied" respondents, comparative group, and "dissatisfied" respondents

	PMP							
	N	1	N	2	N	3	N	4
Satisfied	15	8.07	110	8.54	86	7.70	12	9.50
Comparative group	54	8.43	296	8.57	163	8.54	24	8.42
Dissatisfied	1	8.00	11	8.82	9	9.67	1	18.00

Highest possible score=21; lowest possible score=0

respondents of category 4 have the highest TUMC and GSP scores and the third highest SD score. It is to be noted that category 4 contains only highly educated, urban residents. It is plausible to assume that they are sophisiticated enough to recognize doctors' expertise and therefore, place demands on them that are commensurate with this expertise. They do not expect them to be divine healers. Consequently, they have a high tendency to consult a doctor on matters of health. In general, a doctor's expertise meets their reasonable expectations of him and so they are highly satisfied. On the other hand, they are also sophisticated enough to recognize a doctor's limitations. The wording of most SD statements is such that a low score would indicate an almost unqualified trust in doctors. This is a little too much to expect from sophisticated people. The comparative group, on the other hand, simply exhibits the normal amount of skepticism in the absence of first-hand experiences.

The evidence to support hypothesis 2 is not altogether clear. It is not supported in relation to TUMC; it is strongly supported in

relation to GSP; it is by and large supported in relation to SD, with two exceptions.

3. Perceived Intensity of Self-Involvement (PISI)

Each category of PMP was divided into three categories of PISI which are henceforth designated as categories of PMP-PISI. The average attitude scores for each category of PMP-PISI for those respondents who were "satisfied" are given in Table X. Table XI records the attitude scores for each category of PMP-PISI (which have any respondents) of those who were "dissatisfied".

Of the 224 respondents who were "satisfied" only 83 could be classified into categories of PISI. Similarly, of the 22 respondents who were "dissatisfied" only 9 could be classified into categories of PISI. This discrepancy is explained by the fact that the respondent was asked the "main reason" for his doctor visit. Of the six possible answers to that question, only two--"sickness or illness" and "accidental injury"--required the respondent to answer the PISI questions.

For hypothesis 3 to be supported, the attitude scores of TUMC and GSP will have to increase from category 1 to category 3 of PISI; the scores of SD will have to decrease. Inspection of Table X yields a blurred answer. The hypothesis is supported in PMP category 1; in PMP category 2, only in relation to TUMC and SD. Except for the first score, PMP category 3 shows the reverse direction of influence of PISI on attitudes. PMP category 4 is ambivalent.

The scores in Table XI should be highest in low PISI categories for TUMC and GSP and lowest for SD. One striking feature about Table XI

Table X: Average attitude scores of study group who were "satisfied", by categories of PMP-PISI.

Attitude Concept	PISI	PMP N	1	N	2	N	3	N	4
TUMC	1	0		0		3	6.33	1	8.00
	2	3	6.67	11	5.91	12	9.58	1	7.00
	3	2	10.00	24	7.33	23	9.57	3	7.33
GSP	1	0		0		3	12.00	1	9.00
	2	3	11.33	11	10.45	12	10.08	1	14.00
	3	2	11.50	24	9.88	23	9.70	3	9.67
SD	1	0		0		3	3.67	1	9.00
	2	3	10.33	11	8.27	12	5.08	1	11.00
	3	2	8.00	24	8.21	23	8.83	3	9.00

are the many blanks in it. The only comparison possible is in PMP category 3. Here the predicted relationship is supported in a small way for TUMC and SD, but challenged in relation to GSP.

The evidence for hypothesis 3 is ambivalent in both Tables X and XI. The low (or non-existent) N's of both tables need to be taken into account. In view of the ambivalent trends and the low N's exhibited in Tables X and XI, scientific skepticism forbids drawing any conclusions regarding hypothesis 3 other than the one that more research is needed before the hypothesis can either be confirmed or rejected.

Table XI: Average attitude scores of study group who were "dissatisfied," By categories of PMP-PISI.

		PMP							
Attitude Concept	PISI	N	1	N	2	N	3	N	4
TUMC	1	0		0		0		0	
	2	0		0		1	8.00	0	
	3	0		4	6.00	3	7.67	1	5.00
GSP	1	0		0		0		0	
	2	0		0		1	4.00	0	
	3	0		4	8.00	3	5.00	1	10.00
SD	1	0		0		0		0	
	2	0		0		1	11.00	0	
	3	0		4	10.25	3	12.33	1	18.00

D. TESTS OF SIGNIFICANCE

A cursory examination of the tables in this chapter immediately raises the suggestion of testing the statistical significance of the observed differences. In one sense, tests of significance would definitely be in order. There are, however, numerous reasons why such tests would be of questionable value. Several of these reasons are related to the data collection methods used in the Alberta Health Care Study. They do not satisfy certain important assumptions underlying tests of significance. These assumptions, and the methodological factors which fail to satisfy these assumptions, will be discussed in the following section.

1. Assumption of Independence [3]

In testing for statistical significance one assumes that the population sample is selected in an unbiased way, so that all members of the total population have an equal chance of being included in the sample. There should be no external selective factors operative in obtaining the sample. It requires that "the choice of one individual [has] no bearing on the choice of another individual to be included in the sample." [4]

This assumption is clearly not met by the sampling methods employed in this project. First, area sampling was used. External criteria were involved in the choice of several enumeration districts. The possibility of inclusion in the sample was thereby significantly restricted. Furthermore, the possible combinations of individuals was limited as a result of this technique.

The assumption of independence is violated by another selective factor. For several reasons it was desirable to have "unattached" individuals--those who have no medical insurance coverage--comprise approximately 50 percent of the sample. A rough estimate of the actual distribution in the population is 80 percent "attached" and 20 percent "unattached."* As a result, the "unattached" segment of the sample population is overrepresented to a considerable degree.

A third violation of the assumption of independence is due to proxy interviews. No attitude questions were answered by proxy. Consequently, all proxy interviews were eliminated from the sample.

2. Assumption of Normality

Probability theory is based on the assumption that a property is distributed approximately normal in a population. It has already been argued that the sample used in this study is not representative of the population. Consequently, normality cannot be safely assumed. Blalock, however, contends that "whenever N is large enough we can completely relax the assumption about normality of the population and still make use of the normal curve in our tests."[5]

In our study, the N of the "dissatisfied" group for each category of PMP is rather small; far too small to assume normality for it. Furthermore, the difference in N's between the "satisfied" and the "dissatisfied" group is substantial. In PMP categories

*The data collection team found this to be so.

2 and 3, the N for the "satiafied" group is large enough to be approximately normal. A test of significance would therefore be comparing the mean of a normal distribution to the mean of a distribution whose normality is far from certain. The calculation results would therefore be rather meaningless.

The observation that two important assumptions of significance tests are not satisfied by the research techniques and the size of the N would make the results of their application rather questionable. For that reason, no test of significance has been used.

The question might then be asked whether the findings of this study have any value, since their statistical significance is in doubt. This doubt can be reduced considerably, however, if it is kept in mind that the validity of the major arguments of this study does not require the assumption of normality to hold. The total sample is divided along variables which are thought to influence the distribution of the property in questian in a definite way and direction. It is therefore expected that the distributions are skewed.

E. SUMMARY AND CONCLUSIONS

The survey data analysed in this chapter supports hypothesis 1: Subjects who have had satisfactory role-encounters with a given attitude object exhibit a more favorable attitude toward the object than subjects who have had dissatisfying role-

encounters with similar attitude objects. The difference in attitudes between satisfied and dissatisfied respondents is shown in all three attitudinal concepts with GSP exhibiting the greatest difference.

Hypothesis 2 also is supported by evidence from the survey data. Direct role-encounters have a greater impact on a person's attitude than do symbolically communicated role-encounters. The fact that TUMC scores do not support this hypothesis is explained by the peculiar nature of that attitudinal concept in relation to the subjects on whom is tested. Those who have not utilized medical care facilities for a considerable period of time can hardly be expected to exhibit a strong tendency to utilize them. For another apparent challenge to this hypothesis the explanation is offered that sophisticated people can discriminate between doctors' legitimate claims of expertise in limited areas and grandiose claims of wisdom and power.

Hypothesis 3, that the impact of direct role-encounters on a person's attitudes will vary directly with the person's perceived intensity of self-involvement, was neither confirmed nor rejected. The available evidence was conflicting. Furthermore, the available data was so meagre as to make the formulation of conclusions on it a hazardous venture.

In the following chapter several implications of these findings will be discussed.

CHAPTER V

SOME IMPLICATIONS

The primary purpose of this study was to test the adequacy of symbolic interaction theory with respect to attitude formation and change. It was suggested that this theory was deficient in, though not necessarily incapable of, explaining certain empirically confirmed relationships between certain variables and attitude. Practical considerations were a major motive for conducting survey research from which our data was taken. There are therefore, implications for both areas of interest in this study.

A. THEORETICAL IMPLICATIONS

1. Direct versus Symbolic Role-Encounters

The examples used by symbolic interactionists to illustrate the effect of an actor's experience on his subsequent attitude and behavior involve, for the most part, direct role-encounters. At the same time, symbolic interactionists insist that man can be influenced in his attitude and behavior toward specific objects or situations by symbolic communication without encountering these objects or situations. There is no logical contradiction between these two points of symbolic interactionism. A problem arises when one considers the fact that many objects or situations are encountered in both ways, directly and symbolically, by the same individuals. Which type of encounter takes precedence with respect to influencing the individual's subsequent attitude

and behavior regarding that object or situation?

Verification of hypothesis 2 of this study indicates that the direct role-encounter exerts a greater influence on attitude than does the symbolic role-encounter. Incorporation of this aspect into symbolic interactionism will increase its explanatory and predictive power.

2. Affective Aspects of Role-Encounters

The necessity of extending symbolic interactionism to include the differential weight of influence of various emotional factors in encounters is indicated by the verification of hypothesis one. Previously, symbolic interactionism predicted that a person's encounter with an attitude object would influence his attitude toward that object. It can now be extended to include something about the nature of that influence from a given type of encounter, namely that a satisfactory encounter with an attitude object will influence the person's general attitude toward that object in a favorable way even in areas that were not directly implicated in the encounter. Satisfied persons exhibited a greater tendency to use medical care and less skepticism toward doctors than did dissatisfied persons.

The explanation offered for one discrepancy in the findings raised an interesting question, namely whether degree of sophistication affects the impact an encounter has on a person's attitudes. A sophisticated group of respondents exhibited a high degree of satisfaction with doctors and at the same time were highly skeptical

toward them as well. It is possible that they were favorably inclined toward doctors in relation to the doctors' limited area of specialization, but that they did not transfer this favorable inclination to all that the term "medical doctor" stands for. This conjecture could not be tested with the available data.

Unfortunately, the data did not permit a reasonably adequate test of hypothesis three: That the degree of influence of an encounter on a person's attitude is related to the person's perceived intensity of self-involvement. A test of this hypothesis will requre a greater number of subjects who have had role-encounters with a given attitude object and who fit into different categories of perceived intensity of self-involvement relative to that encounter.

B. A PRACTICAL IMPLICATION

A somewhat surprising observation are the relatively low TUMC scores (tendency to use medical care) of the comparative group. Even those who are dissatisfied with their doctor visit show higher TUMC scores than does the comparative group. Then too, relatively low TUMC scores are found in all categories of PMP, a construct that has some resemblance to socio-economic status. The proportions of subjects belonging to any given category of PMP is roughly the same for both the study group and the comparative group. The comparative group of this study comprises about 25 percent of the total survey sample (Proxy interviews and those who had seen a doctor within the last year but not within the last two weeks were eliminated from our sample).

This finding indicates that neither the quality of medical care nor economic matters have that great an impact on the tendency to use medical care. The question that is left unanswered is: Are those who belong to the comparative group the healthy members of our society, or are their low TUMC scores mostly a reflection of their larger value system? If it is the latter, then what are these values?

During the last few years, Medicare has been a hotly debated topic in Canada. The medical profession, by and large, opposes it on the grounds that the quality of the personal doctor-patient encounter will deteriorate as a result of "third party" interference. Governments favoring Medicare refer to the economic plight of certain segments of our society who are entitled to receive aid, they contend, from society at large in matters so important as personal health. In view of the fervor of the Medicare debate and the findings of our study, it appears that both arguments carry significantly more ideological than empirical weight.

FOOTNOTES

CHAPTER II

[1]P. Pfuetze, Self, Society and Existence, New York: Harper &Brothers, 1961, 43.

[2]S. Stryker, "Conditions of accurate role-taking: A test of Mead's theory," in A. Rose (ed.), Human Behavior and Social Processes, Boston: Houghton Mifflin Company, 1962, 25.

[3]C. H. Cooley, Human Nature and the Social Order, Glencoe, Ill.: The Free Press, 1956, 184.

[4]G. H. Mead, Mind, Self and Society, Chicago: The University of Chicago Press, 1947, XXV.

[5]O. Brim, "Socialization through the life cycle," In O. Brim & S. Wheeler (ed.), Socialization after Childhood, New York: John Wiley and Sons, 1966, 13.

[6]Ibid., 14.

[7]A. Lindesmith & A. Strauss, Social Psychology, Revised Edition, New York: Henry Holt & Company, Inc., 1956, 241.

[8]Stryker, op.cit., 24.

[9]Ibid., 26.

[10]A. Rose, "A systematic summary of symbolic interaction theory," in A. Rose (ed.), Human Behavior and Social Processes, Boston: Houghton Mifflin Company, 1962, 5ff.

[11]Brim, op. cit., 16.

[12]Stryker, op. cit., 58.

[13]M. Deutsch & R. Krauss, Theories in Social Psychology, New York: Basic Books, Inc., 1965, 78.

[14]F. Culbertson, "Modification of an emotionally held attitude through role-playing," J. abnorm. soc. Psych., 54:230-233 (1957).

[15]I. Janis & B. King, "The influence of role-playing on opinion change," J. abnorm. soc. Psych., 49:211-218 (1952)

[16]B. King & I. Janis, "Comparison of the effectiveness of improvised versus non-improvised role-playing in producing opinion changes," J. abnorm soc. Psych., 57:37-40 (1960).

[17]I. Janis & J. Gilmore, "The influence of incentive conditions on the success of role-playing in modifying attitudes," J. Pers. soc. Psych., 1:17-27 (1965).

[18]M. Deutsch & R. Krauss, op. cit., 91.

[19]M. Rosengerg, "When dissonance fails: On eliminating evaluation apprehension from attitude measurement," J. Pers soc. Psych., 1:28-42 (1965).

[20]Janis & Gilmore, op. cit.

[21]A. Cohen, Attitude Change and Social Influence, New York: Basic Books, Inc., 1964, 4ff.

[22]L. Warshay, "Breadth of perspective," in A. Rose, (ed.), op. cit., 152-154.

[23]S. Stryker, "Conditions....." 42.

[24]_____, "Symbolic interaction as an approach to family research," in B. Faber (ed.), Kinship and Family Organization, New York: John Wilgy & Sons, 1966, 24-32.

[25]L. Cottrell, "The analysis of situational fields in social psychology," in P. Hare, et al, (ed.), Small Groups, Revised Edition, New York: Alfred-A-Knopf, 1966, 63.

[26]Janis & King, op. cit.

[27]King & Janis, op. cit.

[28]Janis & Gilmore, op. cit.

[29]W. Watts, "Relative persistence of opinion change induced by active compared to passive participation," J. Pers. soc. Psych., 5:4-15 (1967).

[30]Culbertson,op. cit.

[31]H. Becker, "Becoming a marihuana user," Am. J. Soc. 59:235-242 (1963).

[32]_____, "Marihuana use and social control," in A. Rose (ed.), op. cit., 589-607.

[33]L. Festinger, "A theory of social comparison processes," in P. Hare, et al, (ed.), op. cit., 148.

[34]Ibid., 149.

[35]Stryker, "Conditions....."

[36]Ibid., 58.

[37]M. Smith, "The personal setting of public opinions: A study of attitudes toward Russia," in H. Proshansky & B. Seidenberg (ed.), Basic Studies in Social Psychology, New York: Holt, Rinehart & Winston, 1965, 129-139.

[38]Ibid., 133-134.

[39]Ibid., 137.

[40]R. Kanungo & S. Dutta, "Retention of affective material: Frame of reference or intensity?" J. Pers. soc. Psychol., 4:27-35 (1966).

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CHAPTER III

[1]R. Francis, "Scaling techniques," in J. Doby (ed.), An Introduction to Social Research, Second Edition, New York: Appleton-Century-Crofts, 1967, 198-205.

[2]E. Suchman, "Social patterns of illness and medical care," J. Health and Human Behavior, 6:2-16.

[3]H. Blalock, Social Statistics, New York: McGraw-Hill Book Company, Inc., 1960, 108-112.

[4]Ibid., 109.

[5]Ibid., 138.

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